Schwartz Laser Eye Center

PATIENT INFORMATION

Please Print Clearly ***FILL IN ALL BLANK AREAS***

Date_____

Name Choose One: _____ _____ _____
Last First Middle Initial

Date of Birth _____ Age _____ Choose One: Referred by:_____

_____ _____ _____ _____
Current Street Address City State/Prov PC/Zip Code

Telephone/Home ( ) _____ E-Mail _____

Telephone/Cell ( ) _____ Work Telephone _____

Employer_____ Occupation_____

Name of Person to contact in case of emergency _____

Daytime telephone ( ) _____ Relationship_____

In addition to contacting me by phone or automated dialing system, I authorize Schwartz Laser Eye Center to contact me via:
E-Mail_____ Text_____ All_____

I authorize Schwartz Laser Eye Center to share my medical information wih the following person(s).

Name:_____ Relationship_____Phone#_____

Patient Signature:_____ Witness Signature:_____Date_____

INSURANCE INFORMATION (Required Information)

Insurance Provider _____ Provider Phone # ( ) _____

Address Claims submitted to _____ City _____ State ____ Zip _____

SS # _____ Marital Status _____ Spouses Name _____

Primary SS#_____ Primary Birthdate_____ Primary Cardholder_____

OCULAR HISTORY

Eye medications presently taking: _____

Do you currently use artificial tears? No If yes, what type and how often?_____

How old are your current glasses? _____ Years/Mos How often has your prescription changed? _____

Do you currently wear contact lenses? No If yes, what type? ☐ Soft Daily ☐ Soft Toric ☐ Soft Extended

How long have you worn contact lenses _____ Yrs/Mos ☐ Hard/Gas Permeable ☐ Monovision?

If Extended wear contacts, how often do you remove them? _____ Clean them? _____

When was your last eye examination? _____ Where? _____

Do you have any of the following or a history of the following? (Please answer all)

Iritis	No	Retinal tear/detachment	No	SPECIFY ANY OTHER EYE ISSUES:_____
Eye Injury	No	Lazy / Crossed Eye	No	
Cataract	No	Keratoconus	No	_____
Glaucoma	No	Family history of Glaucoma	No	
Dry Eyes	No	Macular Degeneration	No	Family History of Macular Degeneration Y / N

Do you have a history of any eye surgeries? Y / N If yes, please specify _____

*****PLEASE SEE OTHER SIDE*****